



AMERICAN ACADEMY *of* ACTUARIES

**Subcommittee on Courts and Competition Policy
United States House of Representatives**

**Hearing on
H.R. 3596, the “Health Insurance Industry
Antitrust Enforcement Act of 2009”**

**Statement of James D. Hurley, ACAS, MAAA
Medical Professional Liability Subcommittee
American Academy of Actuaries**

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The American Academy of Actuaries (“Academy”) is a 16,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

Chairman Conyers, Ranking Member Smith, and members of the Subcommittee.

Thank you for inviting me to testify regarding H.R. 3596, the proposed Health Insurance Industry Antitrust Enforcement Act. My name is Jim Hurley. I am a consulting actuary with the firm Towers Perrin, working in the firm's Atlanta, GA office. I have worked for the Firm for approximately 25 years and am an Associate of the Casualty Actuarial Society and a Member of the American Academy of Actuaries. My work is primarily in the medical professional liability area and my comments will be from that perspective rather than from the health insurance perspective. Additionally, my comments will be from the perspective of someone who is frequently looking to estimate medical professional liability loss costs and, often, ultimately rates to be charged by insurance companies to insure such losses or for physicians and entities self-insuring their own medical professional liability exposure. In other words, my perspective is that of an actuarial practitioner actively working on medical professional liability problems daily.

Before providing my comments, it is important to recognize the unique characteristics of medical professional liability coverage. In comparison to other lines of insurance, medical professional liability is a low-frequency, high-severity, long-tailed coverage (meaning, on average, there is an extended period of time between the occurrence of an event, the report of a claim related to the event, and the ultimate resolution of the claim). From a statistical standpoint, this makes the estimation of losses and premium rates more uncertain than for other lines of insurance, such as most types of health insurance. The low-frequency, high-severity, long-tailed nature of medical professional liability coverage contributes to the volatility in its coverage rates. This uncertainty is one of the reasons the coverage is often written on a claims-made basis rather than occurrence basis like most other property/casualty coverages.

In the time allowed, I would like to comment on:

1. Concerns regarding the bill's language and possible misinterpretations;
2. Issues relating to data collection, aggregation and analysis of medical professional liability data; and
3. Some of the potential purposes and consequences of the proposed legislation.

From a practitioner's perspective, the explicitly stated impact of the legislation would seem a non-event on its face. The proposal states, in part, that nothing in the McCarran-Ferguson Act (the 'Act') shall be construed to permit...issuers of medical malpractice insurance to engage in any form of price fixing, bid rigging or market allocations. My understanding is that engaging in these acts in the context of the proposed legislation is illegal pursuant to state laws enacted after implementation of the McCarran-Ferguson Act. In my experience, companies do not engage in collusive price-fixing, bid-rigging, or market allocation. However, possible interpretations of the words 'in any form' raise potential issues and consequences.

In particular, it is possible that the words 'in any form' as contained in the proposal, could preclude the collection, aggregation, and analysis of data across companies.

Currently, such analyses are permitted in accordance with the provisions of the McCarran-Ferguson Act and with the oversight of state regulators. Results of these analyses can be provided to companies that participate in the data collection or, perhaps, to other entities that may be given the opportunity to purchase the information.

By way of background, in general, property/casualty insurance companies are required as a condition to being licensed to designate an entity to which they will report data. Probably the most well-known of these entities is Insurance Services Office (ISO). ISO is approved by the states to operate in this capacity as well as to analyze data and make results available to participants and others, subject to state regulations establishing the rules as to what types of analyses are permitted.

These analyses of aggregated data, or data aggregation serve several purposes, which align with the original intent of the Act and assist state regulators charged with overseeing the pricing of insurance coverage. A few of these purposes are:

1. These analyses provide more credible data upon which to base loss estimates and premium rates. In the absence of this information, companies or self-insured entities would be forced to rely on their own, more limited data to make loss or rate determinations. Reduced access to data could increase the volatility of these determinations from year to year as companies are forced to establish rates using less credible data.
2. These analyses also serve to enhance competition. Without access to industry information, existing companies may be less willing to provide products in new markets or to different types of exposure because of the greater uncertainty associated with determining loss estimates and premium rates.
3. As further support to competition, industry information is of particular importance to newly formed companies or self-insurers looking to begin covering medical professional liability exposure. Absent the use of industry information, they may be reluctant to assume or retain this exposure. Their decision not to provide coverage reduces competitive alternatives in the marketplace.
4. Such industry analyses serve as guidance for companies, self-insurers, and regulators in reducing the likelihood of insolvencies, a long-term and recent concern. Through the review of industry data, companies, self-insurers, and regulators are better able to evaluate if too little is being charged or not enough is being set aside in reserves for a given exposure situation.

These data aggregations serve the purposes outlined above, particularly for medical professional liability which, as suggested earlier, has characteristics that make it a statistically challenging exposure for companies and self-insurers. A few examples may help illustrate some of the challenges. For this coverage, any single company's own data, even for relatively large companies, is often not sufficiently credible to determine basic loss costs in multiple markets. Thus, a company writing a small amount of business in a given market may not have sufficiently credible data to estimate a stable and reliable loss cost for that jurisdiction. In another example, industry analyses can also provide guidance to companies and self-insurers regarding reasonable charges for higher limits of

coverage. For instance, the experience of an individual company or self-insurer is probably not sufficient to estimate losses at \$10 million or \$20 million limits of coverage. Additionally, a single entity's data would rarely be sufficient to determine the appropriate differentials among types of exposure. For example, what would be an equitable loss cost differential among a family practice physician, a general surgeon, and an obstetrician?

There are a number of possible consequences of not having credible information to assist in making loss cost determinations. Such entities, in the interest of preserving their viability, would be more cautious, if not unwilling, to assume exposure given the risk of the coverage. Remember, these industry analyses facilitate having such information available for new small companies, self-insurers, and large established entities looking to cover this exposure in new states.

Thus, the end result relating to medical professional liability insurance companies is likely to be reduced availability with fewer willing insurers, less vigorous competition among those that do write the coverage, and higher costs to the consumer. Self-insurers are likely to be less willing to retain exposure, reducing their risk financing options and possibly increasing their costs as well.

It is my understanding that one stated purpose of the proposed legislation is to reduce medical professional liability premiums. In my opinion, this change will not accomplish that purpose. In fact, it is more likely to have the opposite effect for the reasons I have outlined above.

Additionally, medical professional liability losses and rates have been flat or declining in the last two to three years without the influence of this proposed change. Attached to the written version of this testimony is an exhibit containing a graph obtained from the *Medical Liability Monitor*, which summarizes the results of their annual survey for the last three years. The graph shows the distribution of the percentage change in filed rates implemented by physician insurers and that, in the last three years, approximately 30% of the observations reflect rate reductions. These trends occurred following the implementation of, and debate about, tort reforms in many states as well as the growing impact of risk management and patient safety initiatives.

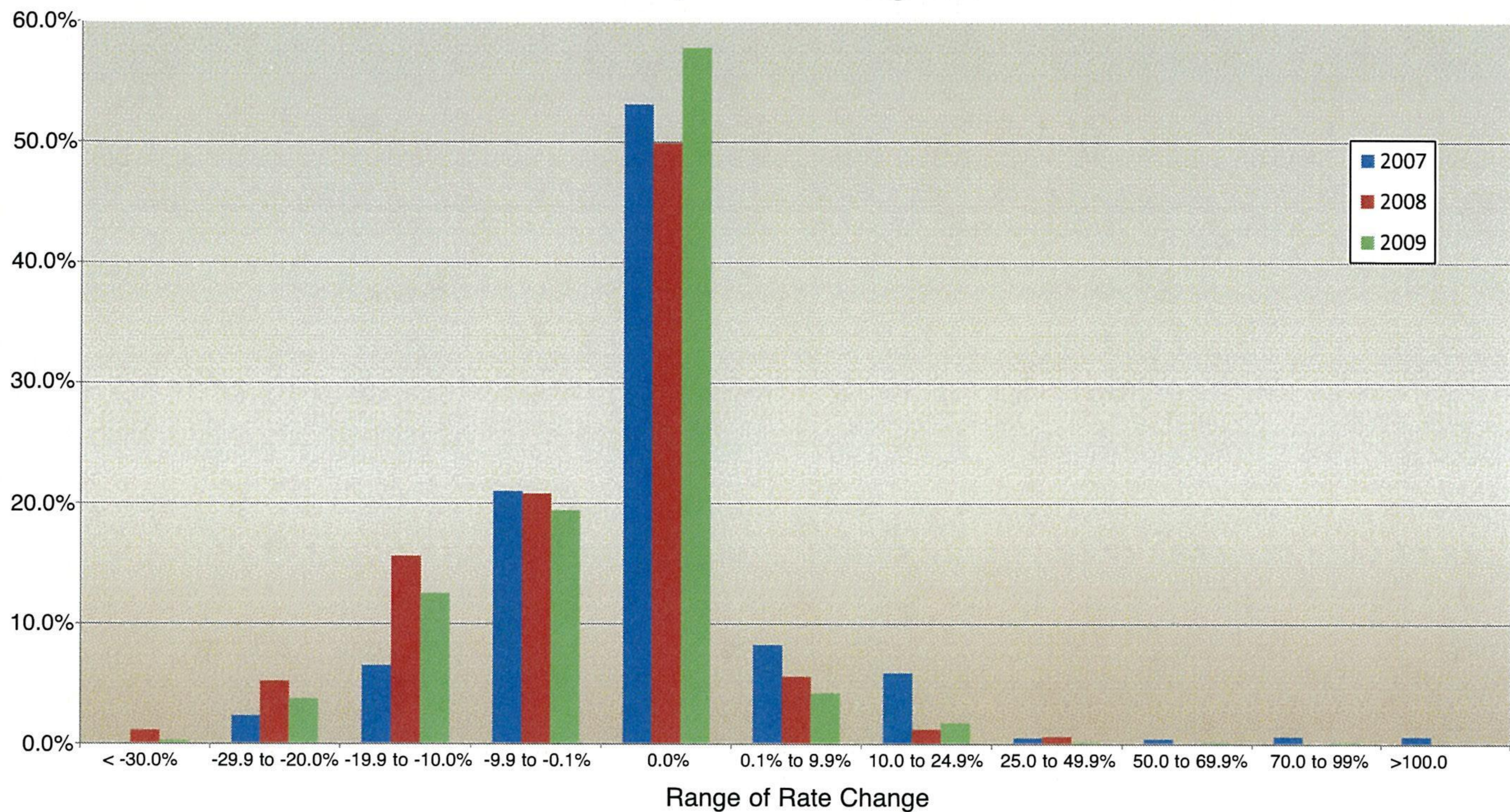
In summary, I note the following –

1. the broad intent of the proposal is already being effectuated at the state level;
2. clarification of other implications (e.g., data collection and analysis) of the bill would help affected parties better understand the impact of the change;
3. collection, aggregation, and analyses of data is an important element of the current environment; it supports better decisions, promotes competition, and aids in protecting solvency; particularly for new and/or smaller competitors;
4. consumers benefit from a more competitive marketplace given the above;
5. implementation of this proposal will not assure lower medical professional liability premiums; it may, in fact, increase them; and

6. medical professional liability rates have been declining without this change, coincidental with the timing of tort reforms, and the growing impact of risk management and patient safety initiatives.

Again, thank you for this opportunity to comment on the proposed legislation, and I will be happy to answer any questions you might have related to these comments.

Distribution of Rate Changes in MLM Survey by Range
Survey Years 2007 through 2009



METHODOLOGY

In this issue of the MEDICAL LIABILITY MONITOR, we bring you our 19th Annual Rate Survey. This survey provides a continuing overview of changing rates for physicians' liability insurance. It is a snapshot in time, reporting rates effective July 1, 2009.

It is a picture we paint state by state because where physicians practice largely determines the premiums they pay. This is because insurers base their rates on the aggregate claims experience in a particular geographic area.

Because state insurance departments may regulate rates, state tort reforms can affect the cost and patient compensation funds may influence the total premium, it is impossible to project a common national picture.

Each year we survey major writers of liability insurance for physicians. We ask for manual rates for specific mature claims-made specialties with limits of \$1 million/\$3 million, by far the most common limits. These are the rates reported unless otherwise noted.

We report on three specialties to reflect the wide range of rates charged: internal medicine, general surgery and obstetrics/gynecology.

With the exception of Medical Protective, all rates shown were volunteered by their respective companies. Medical Protective has historically opted not to participate in the Rate Survey; the company's rates published herein were obtained through independent research and believed to be accurate.

The rates reported should not be interpreted as the actual premiums an individual physician pays for coverage. They do not reflect credits, debits, dividends or other factors that may reduce or increase premiums. Rates reported also do not include other underwriting factors that can increase premiums.

States without compensation funds, by far the largest group, are reported first. Patient compensation fund states are grouped at the end of the survey.

In patient compensation fund states, physicians pay surcharges ranging from a modest percentage to more than the base premium. Also, limits of coverage can differ in these states, which is noted.

When we contact survey participants, we ask them to provide data on all the states in which they actively market to physicians. We only report rates for companies that maintain filed and approved rates for each state in which they sell physicians malpractice insurance. We try to capture the leading, active writers in each state, but every writer may not be included.

In comparing this year's report with previous reports, it will be evident that the market is always changing. Many companies, formerly included, no longer sell physicians' malpractice insurance in certain states, do not currently entertain new business, have withdrawn from this line of insurance or no longer exist. The companies shown were available for business July 1, 2009.

We estimate that this survey represents companies that comprise 65 to 75 percent of the market, and as such, is the most comprehensive report on medical liability rates anywhere.

The expanded rate report could not have been completed without the cooperation of the many people who work in the companies surveyed. Their cooperation is invaluable in providing this information to all who have an interest in this field.